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A Case of Head and Foot Presentation

Fracture of the Spine in Utero

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WASHINGTON, D. C.

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A CASE OF FOOT AND HEAD PRESENTATION; FRACTURE OF THE SPINE IN UTERO.

BY JOSEPH TABER JOHNSON, M. D.,

Washington, D. C.

On the night of March 4, 1878, I was requested by Dr. S. to visit his wife, who was then in labor with her third child. She was a strong healthy woman, twenty years of age, and her previous labors were both completed in less than two hours. She had in the former cases recovered rapidly, and had never suffered from any uterine disease.

This labor set in at two P. M. She made good progress, and at four P. M. the waters broke and a midwife in attendance diagnosticated a breech presentation preceded by a foot. The doctor was not at home, and did not reach his house until nine P. M. He ascertained that his wife's pains had been increasing in frequency and intensity up to about that hour, but had, from that time, gradually diminished in strength, until they finally ceased to produce any further descent of the presenting part, and were simply a source of aggravation and discouragement.

Upon examination, having in mind the midwife's statement, he thought he confirmed her diagnosis of a breech and footling presentation. The vagina was hot and dry, the pulse 120, and she was restless, feverish, and apprehensive of speedily approaching death. I arrived at 1 A. M. Her restlessness and anxiety had been constantly increasing until she had now become almost unmanageable. It was impossible to complete a diagnosis until the vulva and vagina had been thoroughly lubricated and softened with oil, and her restlessness was so great that her husband

and nurse were obliged to restrain her while I made the examination.

The right foot was found in advance of the head, which was presenting with the occiput to the right acetabulum and was crowned by a large puffy *caput succedaneum*, which had been mistaken for a breech. Although the necessity for speedy delivery was apparent, I was unable to push up either the foot or the head and thus dissolve the wedge, as Barnes calls it, and secure a simple head or footling presentation ; I sent at once for chloroform and ergot, but fully an hour elapsed before they could be obtained. In the mean time uterine contractions came on again with such power, that I feared rupture of the walls of the organ, and besought the patient not to bear down, and endeavored to calm her fears and jactation until the arrival of the chloroform. Previous to her coming under its influence the pains had driven the presenting parts through the brim of the pelvis, and the walls of the uterus so firmly compressed the body of the child that I found, when I came to explore the parts fully, that it was then practically impossible to change the presentation into a more favorable one, in spite of persistent efforts.

The doctor and his wife were both positive that the child was alive at nine o'clock. Very careful but unavailing examination was made for signs of life, after the patient became manageable under chloroform. Having in remembrance the experience of Cazeaux,[1] in a similar case, where the left foot presented in advance of the face of the child, in which both he and the attending physician exhausted themselves in fruitless efforts to deliver with the forceps, and finally had to deliver by craniotomy, I was inclined to lose no time, but to proceed at once to perforate and to deliver with the cranioclast. It did not seem wise, when the head was so wedged in the pelvis, with the foot and ankle swollen and immovable, to waste time by a trial of the forceps.

The husband, however, had such a horror of craniotomy,

[1] *Traité des Accouchements.*

that I yielded to his earnest entreaties and applied after some difficulty, the blades of Simpson's forceps, and locked them. Her pulse was then 140 and her temperature 101.5.

Upon making traction the instrument at first slipped, but it was reapplied, and retained its grasp upon the head, which, after the expenditure of much force, advanced ; the foot, all the time retaining its relative position, first made its appearance at the vulva; the head soon followed and the child was born. A full dose of Squibb's fluid extract of ergot was administered, and the placenta delivered by expression.

The patient recovered well from the effects of the anesthetic, and was placed comfortably in bed. She made an excellent recovery, was about the house in ten days and in three weeks from the time of her delivery walked two squares to attend church.

The child was still-born, and had its spinal column fractured in the lower third of the dorsal region. When put on a table, the angle in its body we concluded was about the same which it must have acquired while undergoing its severe compression *in utero*, having a projecting point in the middle of its back. In order for the foot and ankle to have presented at the side of, and in advance of the head, the force of the uterine contractions must have been expended in such a direction as to drive the head and pelvis of the child into the parturient canal at the same time. The vertebral column could not withstand this force, and gave way and was fractured, as above mentioned.

The skin was mottled and ecchymosed in patches, which, after being washed, presented the appearance of bruises or contusions. The fetus was literally squeezed to death. It bore evidence of having ceased to live only a short time previous to delivery, indeed, so uncertain were we of its actual death, that we continued for some time to use the various means for restoring it to life. In presenting the history of this, to me, remarkable case, I desire to make a single statement in regard to the treatment.

The question will probably occur to some of the gen-

tlemen present, why was any operation necessary when the pains had revived, and become so continuous and powerful that the head had made some progress. Very soon after my first examination the uterus seemed provoked into vigorous and rapid contraction, which simulated closely the tetanic rigidity induced by large doses of ergot.

The vertex and lower extremity being at once in the pelvic cavity, as the larger portions of these presenting parts advanced they became firmly wedged in the pelvis, and made no further progress in response to the most frequent and vigorous pains. No advance was made during the last hour of the labor. The maternal parts were becoming more heated and dry, the pulse and temperature were far above normal, the uterus was in danger of rupture, the compression of the soft parts was great, and the patient liable to the supervention of fatal exhaustion. Her only safety was in as speedy delivery as was compatible with the preservation of the integrity of her structures.

It is quite probable that had the child been turned at nine o'clock it might have been born alive, and had the mother's restlessness and refusal to remain quiet without chloroform, not prevented, I could probably have delivered by version, or at least changed the presentation for one more favorable, upon my arrival at 1 A. M. The hour consumed in the search for anesthetics was the golden opportunity which was lost, so far as the child was concerned. My experience in prolonged labors and in the causation of puerperal diseases has pretty thoroughly convinced me that the danger in most of these cases is in proportion to the length of the second parturient stage, and that our prophylaxis is successful, in proportion to our ability to shorten that stage and thereby relieve the maternal soft parts from pressure.

Compression by the impacted fetal head is a most prolific cause of the various inflammations, sloughing of tissue, fistulæ, exhaustion, and puerperal fever from absorption of septic material.

Recent analyses of the statistics of forceps cases with

especial reference to these points made by Braxton Hicks,[1] and Phillips of London, Kidd[2] of Dublin, Emmet,[3] Busey,[4] and others in this country, should have great weight, if they do not convince us that these conditions are produced, *not* by the too early or too frequent resort to the forceps in cases of delay in the second stage, as is *claimed* by those who oppose the modern use of this noble instrument; but by the *neglect* to resort sufficiently early to artificial means for expediting the delivery, where impaction has occurred.

In presenting the history of a case, a discussion of the forceps operation is hardly in place, and I do not intend to discuss it, but would simply say that it seems to me that great good could be done by our society in giving its authority and assent to the statement that the forceps operation should be regarded by the profession, generally, as a means of *preventing* danger to both the mother and child, as well as a means of rescuing the mother from an actual danger when she has drifted into it.

I know of no case in obstetric literature which bears a very close resemblance to the one of which I have had the honor to read the history here to-day. Hence I present it more for the purpose of placing it upon record in the next volume of our Transactions, than with the thought of eliciting discussion.

[1] *Obst. Trans.*, vol. xiii.

[2] *Inaugural Address, Dublin Obst. Society*, 1871.

[3] *Vesico-vaginal Fistulæ.*

[4] In a contribution to the *Amer. Jour. of Obst.* (vol. iv., p. 253, 1872), entitled, "Impaction a Cause of Vesico-vaginal Fistulæ," Dr. Busey has shown by an analysis of the cases of vesico-vaginal fistulæ reported by Dr. Emmet in his work on *Vesico-vaginal Fistulæ*, that delay in effecting delivery after impaction has occurred is the cause of the accident, which an earlier resort to the forceps might have prevented. He has also demonstrated by the same analysis that the early application of the forceps saves the lives of many children.

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